

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

13050

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No.
Registered No. **3605**
St. Ward)

2. FULL NAME

(a) Residence. No. **John B. Butyorek** St. **B** Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Theresa Butyorek**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct 15 - 1856**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	72	5	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Laborer**
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Ungarn**

10. NAME OF FATHER **Michael Butyorek**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Ungarn**

12. MAIDEN NAME OF MOTHER **not known**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Ungarn**

14. INFORMANT **Miss Hoffmeyer** (Address) **4160 Maple St**

15. FILED **21** 19 **Nov 2** **May C. Starkey** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 21 1929**

17. I HEREBY CERTIFY That I attended deceased from **21**, 19**29**, to **23**, 19**29**, and that I last saw him alive on **21**, 19**29**, and that death occurred, on the date stated above, at **3:00** p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Supercarotid
Life long unrel Heroin
1228
Phrenic Nerve cateter
Cardiac Dilatation

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **3/5/29**

19. WAS THERE AN AUTOPSY? **no**
WHAT TESTS CONFIRMED DIAGNOSIS? **Autopsy**

(Address) **3458 S. Grand St**
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **St. Peter and Paul** DATE OF BURIAL **March 25 1929**

20. UNDERTAKER **Greender U. Co** ADDRESS **1718 Log St**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

72 2 2 2 2

